COMMUNITY CARE LICENSING DIVISION

"Promoting Healthy, Safe and Supportive Community Care"

TECHNICAL SUPPORT PROGRAM

Self-Assessment Guide

ADULT RESIDENTIAL FACILITY PREADMISSION QUESTIONNAIRE

CDSS

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

TECHNICAL SUPPORT PROGRAM

ADULT RESIDENTIAL FACILITY

PREADMISSION QUESTIONNAIRE

The following questionnaire is designed to assist adult residential facility staff to identify specific issues that may affect the placement of and/or services to be provided to prospective residents of Adult Residential Facilities. The questions on this list should be reviewed with the applicant's responsible party prior to admissions to the facility. If the answer to any of the questions on this list is yes; the intake staff should gather information to determine whether or not the facility will be able to admit the resident and meet his/her needs.

The information on this form supplements the Needs and Services Plan form (LIC 625), but does not replace it. While the information gathered from this form should assist staff in making appropriate placement decisions, it is not a required form and does not constitute a preadmission appraisal.

Date:_____

Applicant's Name:_____

Current Residence:_____

Reason for Placement:
_____
_____
_____
_____

YES **NO**
☐ ☐ Is the client a registered sex offender? (Information required per H & S 1522.01) If yes, provide information on offense(s)_____
_____
_____

A. MENTAL/DEVELOPMENTAL STATUS

Does the client have any of the following diagnosis:

YES **NO**
☐ ☐ 1. Mental disorder
☐ ☐ 2. Developmental disability
☐ ☐ 3. Dual Diagnosis

1. If the answer to any of the above is yes, please describe:

The condition:_____
_____
_____
_____

The severity of the disorder or disability:_____
_____
_____

MENTAL/DEVELOPMENTAL STATUS (continued)

Any current or previous treatment:_____
_____
_____
_____

B. HEALTH STATUS

Client's primary physician name and phone:_____
_____

YES	NO	
☐	☐	Does the client use any prescription medications If yes, please list prescription:_____ _____ _____
☐	☐	Does the client use any nonprescription medications If yes, please list non prescription:_____ _____ _____

Does the client have any of the following:

YES	NO		
☐	☐	1.	Asthma
☐	☐	2.	Epilepsy
☐	☐	3.	Allergies
☐	☐	4.	Diabetes
☐	☐	5.	Eating disorders
☐	☐	6.	Visual impairment
☐	☐	7.	Physical impairment
☐	☐	8.	Infectious disease
☐	☐	9.	Special Diet
☐	☐	10.	Pregnancy
☐	☐	11.	Chronic medical condition
☐	☐	12.	Incontinence

If the answer to any of the above is yes, please describe:

The type and severity of the condition:_____
_____
_____
_____
_____
_____

The treatment the client is receiving for the condition:_____
_____
_____
_____
_____

The names and dosages of medications the client receives:_____
_____
_____

HEALTH STATUS (continued)

Any medical apparatus the client needs as a result of the condition:_____
_____
_____

Any limitations due to the condition:_____
_____
_____
_____
_____

Any special services required due to the condition:_____
_____
_____
_____
_____

C. FUNCTIONAL STATUS

Do any of the following conditions apply to the client:

YES	NO		
☐	☐	1.	Non-ambulatory
☐	☐	2.	Bedridden/bedfast
☐	☐	3.	Paralysis
☐	☐	4.	Contracture
☐	☐	5.	Inability to transfer to and from bed
☐	☐	6.	Needs assistance with eating, bathing, dressing, grooming, or toileting

If the answer to any of the above is yes, please describe:

The type of limitation and its severity:_____
_____
_____
_____
_____

Any assistive devices used by the client:_____
_____
_____
_____
_____

Any treatment or therapy needed by the client as a result of the condition:_____
_____
_____
_____
_____
_____

D. BEHAVIORS

Does the client have a history of any of the following:

YES	NO		
☐	☐	1.	Physical assaultiveness
☐	☐	2.	Verbal assaultiveness
☐	☐	3.	Sexual assaultiveness or molestation
☐	☐	4.	Violence to self or others
☐	☐	5.	Cruelty to others
☐	☐	6.	Attempts to poison others
☐	☐	7.	Use of weapons
☐	☐	8.	Cruelty to animals
☐	☐	9.	Destruction of property
☐	☐	10.	Stealing
☐	☐	11.	Arson

If the answer to any of the above is yes, please describe:

The behaviors:_____
_____
_____
_____
_____

The frequency and duration of the behaviors:_____
_____
_____
_____
_____

The approximate date of the last occurrence of the behaviors:_____
_____
_____

Anything that seems to trigger the behavior:_____
_____
_____
_____

Strategies to deal with the behavior:_____
_____
_____
_____
_____
_____

BEHAVIORS (continued)

Does the client have a history of any of the following:

YES	NO		
☐	☐	1.	Depression or withdrawal
☐	☐	2.	Anxiety
☐	☐	3.	Mood swings
☐	☐	4.	Suicidal ideation
☐	☐	5.	Suicide attempts
☐	☐	6.	Paranoia
☐	☐	7.	Hallucinations
☐	☐	8.	Restlessness or hyperactivity
☐	☐	9.	Inappropriate sexual activity
☐	☐	10.	Confusion with sexual identity
☐	☐	11.	Non-compliance
☐	☐	12.	Refusal to attend therapy

If the answer to any of the above is yes, please describe:

The behaviors:_____
_____
_____
_____
_____

The frequency and duration of the behaviors:_____
_____
_____
_____
_____

The approximate date of the last occurrence of the behaviors:_____
_____

Anything that seems to trigger the behavior:_____
_____
_____
_____

Strategies to deal with the behavior:_____
_____
_____
_____
_____
_____

BEHAVIORS (continued)

Does the client have a history of any of the following:

YES	NO		
☐	☐	1.	Disruptiveness
☐	☐	2.	Tantrums
☐	☐	3.	Wandering
☐	☐	4.	AWOL
☐	☐	5.	Substance abuse
☐	☐	6.	Ingestion of toxic substances
☐	☐	7.	Refusal of medications
☐	☐	8.	Refusal of medical treatment
☐	☐	9.	Refusal to bathe or wear clean clothes
☐	☐	10.	Resistance to authority
☐	☐	11.	Careless disposal of smoking materials

If the answer to any of the above is yes, please describe:

The behaviors:_____
_____
_____
_____
_____

The frequency and duration of the behaviors:_____
_____
_
_____

The approximate date of the last occurrence of the behaviors:_____
_____

Anything that seems to trigger the behavior:_____
_____
_____
_____

Strategies to deal with the behavior:_____
_____
_____
_____
_____
_____

Applicant/Responsible Party:_____
Date:_____
Facility Representative:_____
Date:_____